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COMMENTARY

Integrating Emergency Medicine and Psychiatric Emergency Service Disaster Response

JOSEF I. RUZEK, PHD

In this issue, Drs Ng and Reich review the important and relatively underdeveloped role of psychiatric emergency services (PESs) in disasters and give a useful delineation of issues needing consideration in the preevent, acute, and postevent phases of disaster mental health response.

Hospitals play a major role in disasters and other critical incidents that affect communities, because they are a key place at which survivors affected by a disaster will receive early help. It is also likely that those seen in hospitals will include many persons at highest risk for development of lasting posttraumatic problems: those injured during the event, family members of seriously injured or missing persons, and persons experiencing panic or other intense psychological responses. As Dr Ng notes, in biologic or chemical disasters, the number of psychological casualties is likely to exceed the number of medical casualties.

Dr Ng also draws attention to the fact that the symptoms of some persons with preexisting psychiatric problems may be exacerbated by disaster. In high-intensity events involving much loss of life or severe traumatic exposure, substantial numbers of persons may be at risk for development of post-traumatic stress disorder (PTSD) and other post-trauma problems. In a study of 182 injured adults surveyed 6 months after the Oklahoma City bombing, 34% met criteria for PTSD and 45% had some type of postdisaster psychological disorder.[1] In another study of the same event, 34% of 494 community residents with varying degrees of exposure met full criteria for PTSD 18 to 36 months after the bombing.[2]

Role of the PES

PES teams should be central to the disaster-response role of hospitals and to the minimization of negative mental health consequences of disaster among survivors. The crisis experience, mental health expertise, and preexisting community relationships of PES staff members combine to make them well suited to respond to the psychological needs of disaster survivors. Their knowledge means that they must be seen as a resource for other health care providers. PES staff act as trainers for emergency medical services (EMS) and other hospital personnel to help them better manage patients' fears and better recognize those currently experiencing, or at future risk for, mental health difficulties.

The central challenge identified in the authors' presentations, however, is the need to integrate PES mental health response with emergency medicine disaster response. One obstacle to such integration is the existing separation of EMS and the PES, which reflects earlier ideas of mind-body dualism and the historical structuring of health care services. In primary care medicine, there is an accelerating movement toward integration of physical and mental health care in ways that hold potential for identifying mental health difficulties in medical settings, bringing behavior change methods to bear on problematic health behaviors, improving health and mental health outcomes, and generally increasing attention to the whole person. Such integration should also be explored in emergency medicine settings.

Attention to Staff Wellness

The contributions by Drs Ng and Reich are noteworthy for stressing the importance of staff wellness because, as they indicate, psychological issues have not always been emphasized in wellness programs. Dr Ng's case presentation is useful in drawing attention to the fact that disaster responders are also disaster survivors who may be powerfully affected by the event itself or by their work as a responder. The case illustrates that many disaster workers place the needs of survivors above their own needs, work extremely long hours, and do not abide by the various self-care practices that are commonly recommended; this means that staff self-care must be monitored and strengthened through explicit policies and actions by those who manage disaster workers.

In the case study, the worker "CJ" is currently in treatment for previously existing PTSD and has been experiencing anxiety symptoms as a result of her recent volunteer work at Ground Zero. The information gathered dur-

Dr Ruzek is associate director of education at the National Center for Post-Traumatic Stress Disorder, education and clinical laboratory division, at the Veterans Affairs Palo Alto Health Care System in Menlo Park, Calif. He is also associate professor of psychology at the Pacific Graduate School for Psychology in Palo Alto.

ing assessment helps clarify her situation and leads to the delivery of good advice about coping skills and self-care. A helpful discussion with the woman's supervisor about how to better monitor and support her functioning as a disaster-response worker also takes place. This case, in addition to demonstrating some desirable disaster mental health practices, draws attention to a shortcoming of much current disaster mental health response: persons at some risk for ongoing difficulties are commonly given brief advice but do not receive active follow-up.

Arguably, CJ has a problem with PTSD that is being worsened by her participation in the emergency response. Brief coping advice and information about places to seek additional care may not be sufficient to change her behavior and reduce her anxiety. I would view her as a person who would benefit from follow-up contact with the PES or crisis counseling personnel to determine later whether she is functioning well or needs further help.

The case also underscores the need to establish systems for screening and credentialing volunteers. It seems likely that, given CJ's lack of experience and training in disaster response, and given her ongoing problems with PTSD and her history of traumatic loss associated with fire, she should not have been given work at the scene. Possibly, she should not have been accepted as a volunteer. Dr Ng notes, however, that removing her from volunteer opportunities may now negatively affect her; keeping her involved in the response efforts may be warranted.

Response to Biologic Threat

The need to support staff during disaster response must be seen not only as a way to minimize the emotional toll that such work takes on the employee but also as a means to ensure the continuing ability of hospital staff members to perform emergency duties. This may be especially important in the event of a large-scale terrorist attack or biologic threat, when families of hospital staff may be at continued risk and workers may experience strong conflicts between family and work responsibilities. In this context, Dr Reich's remarks on the importance of communicating with the families of staff are especially well taken.

The case presentation provided by Dr Reich is helpful in broadening the discussion to include biologic threats to the community, an increasingly important topic. Disaster mental health responders currently receive little training in this important area, and strategies for the management of mental health aspects of such threats at both the community and personal levels require greater development. One requirement, Dr Reich suggests, is that mental health personnel must be better trained to recognize organic causes (including exposure to toxins) of changes in behavior and emotional functioning.

Pursuing Integration of Services

Dr Ng draws attention to the very real resource constraints under which PES teams are operating, which may make more difficult their involvement in the various activities necessary to strengthen integration with EMS and engage in adequate preparation for disasters. PES professionals have a broad range of skills that will be immediately useful in disaster, and their more usual professional roles will have some overlap with responsibilities during a community crisis.

As Dr Reich notes, however, disaster mental health services differ in significant ways from typical PES services. Moreover, the variety of issues to which PES providers must respond in a disaster includes not only screening and assessment; triage; and delivery of psychological first aid, medication, and other forms of help, but also staff support, staff education, community liaison, disaster planning, management and credentialing of volunteers, and management of transportation and communication concerns. Many, perhaps most, of these competencies will not have been part of the routine training of PES staff; these skills will have to be developed through systematic education and preparation that is over and above existing work duties.

As the authors indicate, senior leadership must make this a priority and take steps toward enabling PES staff to develop response plans, receive appropriate training, establish links and mutual assistance agreements with other community response organizations, and participate in multiorganizational planning activities and exercises. Leaders must ensure that existing emergency department response plans are reviewed and revised to integrate mental health activity, but as Dr Reich emphasizes, including mental health support in a written plan is not adequate; rather, genuine integration of services at all phases of response is necessary.

Both authors note that mental health aspects of disaster are often relatively underemphasized compared with response to physical injury. It is hoped that their articles prompt hospital decision makers to accelerate the rate at which mental health response elements are integrated into general hospital response plans. It is hoped, too, that the articles will spur creativity regarding the ways in which responsibilities of PES teams are expanded to include substantial roles in disaster-response management. ■

REFERENCES

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